Hysterectomy Acknowledgement Form

Federal law (42 C.F.R. § 441.255) requires that a beneficiary requiring a hysterectomy sign a written acknowledgement, prior to the surgery, that certain information about hysterectomies was received. Complete the following sections.

Beneficiary Name: _____ **Medicaid ID #:** _____

SECTION A. Beneficiary Acknowledgement Statement & Signature: This section must be completed prior to the surgery by the beneficiary and the person obtaining the acknowledgement. If prior acknowledgement is not possible due to a life-threatening emergency, the physician performing the hysterectomy must complete Section C.

A hysterectomy is an operation in which a woman's uterus (womb) is removed. A hysterectomy should be done only when there is a disease or injury of the uterus (or some other medical problem) that can only be treated by removing the uterus. It should be explained to you why a hysterectomy is needed and what discomforts, risks, and benefits may result from the surgery. If you have a hysterectomy, you cannot become pregnant or bear children. A hysterectomy is permanent and cannot be reversed.

If the reason you are having a hysterectomy is to avoid bearing children, you should consider other methods of sterilization, such as tubal ligation (having your tubes tied). The Mississippi Division of Medicaid will not pay for a hysterectomy if the purpose is for birth control. A hysterectomy takes much longer to do than a tubal ligation, and you would be in the hospital longer. There is more discomfort and a greater chance of serious health problems with a hysterectomy.

Acknowledgement That Hysterectomy Information Was Received

I have read the above information about the hysterectomy operation. The discomfort, risks, and benefits that go along with a hysterectomy have been explained to me. All of my questions have been answered to my satisfaction. I understand that if I have a hysterectomy operation I cannot become pregnant or bear children. I understand that a hysterectomy is permanent and cannot be reversed.

Beneficiary Signature: _____ **Date Signed:** _____

Person Obtaining Acknowledgement: _____ **Date Signed:** _____

SECTION B. Physician Certification: This section must be completed by the physician performing the hysterectomy.

I certify that the hysterectomy to be performed on the above beneficiary is medically necessary due to:

_____.

I certify the beneficiary has been informed, both orally and in writing, that the hysterectomy will make the beneficiary permanently incapable of reproducing. I certify that the hysterectomy to be performed on the beneficiary is not being performed solely for the purpose of rendering her incapable of reproducing and the procedure would be performed even if it did not result in the beneficiary being rendered incapable of reproducing.

Date of Hysterectomy: _____ Physician Signature: _____ Date Signed: _____

SECTION C. Emergency Surgery: I certify that because of a life-threatening emergency it was not possible to obtain the beneficiary's acknowledgement statement before the hysterectomy was performed. The nature of the emergency was:

_____.

Date of Hysterectomy: _____ Physician Signature: _____ Date Signed: _____